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28 August 2010

Righting the wrongs

C+D Senate's masterplan to stamp out dispensing error prosecutions pages 5 and 22

CPD ZONE

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Prescribing Information
(Refer to Summary of Product Characteristics before prescribing)
Presentations: Pressurised inhalation solution containing 100 micrograms of beclometasone dipropionate and 6 micrograms of formoterol fumarate dihydrate per actuation. **Indications:** Regular treatment of asthma where use of a combination product (inhaled corticosteroid and long-acting beta$_2$-agonist) is appropriate: patients adequately controlled with inhaled corticosteroids and 'as needed' inhaled short-acting beta$_2$-agonist; or patients already adequately controlled on both inhaled corticosteroids and long-acting beta$_2$-agonists. Not appropriate for treatment of acute asthma attacks. **Dosage and Administration:** For inhalation use only. Fostair is not recommended for the initial management of asthma. If an individual patient should require a combination of doses other than those available in the combination inhaler, appropriate doses of beta$_2$-agonists and/or corticosteroids by individual inhalers should be prescribed. Adults: one or two inhalations twice daily, maximum four inhalations daily. Not recommended for patients under 18 years. Beclometasone dipropionate is characterised by an extra-fine particle size distribution which results in a more effective treatment than formulations of beclometasone dipropionate with a non-extra-fine particle size distribution. 100 micrograms of beclometasone dipropionate extra-fine particles is equivalent to 250 micrograms of beclometasone dipropionate non-extra-fine particles. Therefore the total daily dose of beclometasone dipropionate administered should be lower than the total daily dose of beclometasone dipropionate administered in a non-extra-fine beclometasone dipropionate formulation. Fostair may be used with the AeroChamber Plus™ spacer device. Patients should be advised in the proper use and care of their inhaler and spacer. **Contraindications:** hypersensitivity to any of the components. **Precautions:** cardiac disorders (including coronary insufficiency, cardiac arrhythmias, thyrotoxicosis, diabetes mellitus, untreated hypokalaemia, pulmonary infections (tuberculosis), Fostair should not be used as the first treatment for asthma, and during an exacerbation, or during significantly worsening or acutely deteriorating asthma, and should not be stopped abruptly. If patients find their asthma is no longer controlled medical attention must be sought. Systemic effects of inhaled corticosteroids may occur, particularly at high doses prescribed for long periods. These effects are much less likely to occur with inhaled than with oral corticosteroids. Possible systemic effects include Cushing's syndrome, Cushingoid features, adrenal suppression, decrease in bone mineral density, growth retardation in children and adolescents, cataract and glaucoma. Titrate to the lowest dose at which effective control of asthma is maintained to minimise systemic effects. Special care is needed in transferring patients from oral steroids. Fostair contains a small amount of ethanol (approximately 7mg per actuation); at normal doses the amount of ethanol is negligible and does not pose a risk to patients. Patients should rinse mouth after inhalation to minimise risk of oropharyngeal candida infection. **Drug Interactions:** Beclometasone dipropionate undergoes a very rapid metabolism via esterase enzymes without involvement of the cytochrome p450 system. Avoid beta$_2$-blockers (including eye drops). Caution is required when theophylline or other beta$_2$-adrenergic drugs are prescribed concomitantly with formoterol. Concomitant treatment with quinidine, disopyramide, procainamide, phenothiazines, antihistamines, MAOIs and TCAs can prolong the QTc interval and increase the risk of ventricular arrhythmias. In addition, L-dopa, L-thyroxine, oxytocin and alcohol can impair cardiac tolerance. Concomitant administration with MAOIs, including agents with similar properties such as furazolidone and procarbazine, may precipitate hypertension. Risk of arrhythmias in patients receiving anaesthesia with halogenated hydrocarbons. Theoretical potential for interaction in sensitive patients taking disulfiram or metronidazole. **Pregnancy and Lactation:** No experience. Balance risks with benefits. **Side effects:** *Common:* pharyngitis, headache, dysphonia. *Uncommon:* influenza, oral fungal infection, pharyngeal and oesophageal candidiasis, vaginal candidiasis, gastroenteritis, sinusitis, granulocytopenia, dermatitis allergic, hypokalaemia, hyperglycaemia, restlessness, tremor, dizziness, otosalpingitis, cardiac arrhythmias, hyperaemia, flushing, rhinitis, cough, productive cough, throat irritation, asthmatic crisis, pruritus, rash, hyperhidrosis, diarrhoea, dry mouth, dysopepsia, dysphagia, burning sensation of the lips, nausea, dysgeusia, muscle spasms, myalgia, C-reactive protein increased, platelet count increased, free fatty acids increased, blood insulin increased, blood ketone body increased. *Rare:* ventricular extrasystoles, angina pectoris, paradoxical bronchospasm, urticaria, angioneurotic oedema, nephritis, blood pressure increased, blood pressure decreased. *Very rare:* thrombocytopenia, hypersensitivity reactions, adrenal suppression, abnormal behaviour, sleep disorder, hallucination, glaucoma, cataract, atrial fibrillation, dyspnoea, exacerbation of asthma, growth retardation in children and adolescents, peripheral oedema, bone density decreased. **Legal Category:** POM **Packs and Prices:** Fostair 100/6 (PL08829/0156) £29.32. Each inhaler contains 120 actuations. Full prescribing information is available from the **Marketing Authorisation Holder:** Chiesi Limited, Cheadle Royal Business Park, Highfield, Cheadle, SK8 3GY. **Date of preparation:** July 2010.

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> THOSE FIRST FALLINGS OF THE AXE LOOK SET TO TURN INTO A FULL-BLOWN MASSACRE AS MORE LOCAL ENHANCED SERVICES ARE LOST OR REDUCED

"The first cut is the deepest," warbled Cat Stevens in the swinging sixties. If only his much-covered hit had been a prophecy for pharmacy services in this era of austerity.

If only, after the coalition government unveiled its first, brutal budget, the rumblings we heard last month of minor ailments services being slashed were the end as well as the beginning of pharmacy's worst nightmare.

Instead, those first fallings of the axe look set to turn into a full-blown massacre as, after last week's bad news about Surrey pharmacists' smoking cessation service, C+D reports the loss of or reduction in more local enhanced services (p4).

The good news is that pharmacy services are proving their worth, as the story that southern pharmacies were last year responsible for a significant proportion of their PCTs' smoking cessation successes (p5) shows.

These are the sorts of figures we should, as has often been pointed out on this very page and elsewhere, be gathering more of; if we wave such evidence of pharmacy services' value under PCTs' noses they'll have no choice but to keep running them, right?

Er, wrong – if PSNC's Alastair Buxton is to be believed. His assessment that trusts are ignoring hard facts in favour of an instant fix on the bottom line (p4) calls to mind an image of PCT officers running around like headless chickens that might be amusing if pharmacists' livelihoods weren't at stake.

It gets worse. Not only are PCTs discounting positive evidence in the rush to record a healthy balance sheet but one smoking cessation scheme has become the definition of "a victim of its own success", cancelled after it was so efficacious it "outstripped its budget" (p4). If that isn't a perverse system, I don't know what is.

I don't doubt PCTs are under enormous pressure to cut costs, and that temptation to do so by any means is huge. But to avoid potential long-term damage – to the invaluable community pharmacy network and the wider health service as well as patient care – they really must take a step back and a deep breath, and look at the bigger picture.

And if PCTs won't respond to the carrot, perhaps pharmacies will have to start using the stick. That's the approach taken by one LPC, which has highlighted the probable negative consequences of cutting its minor ailments scheme (p8). Crowded surgery waiting rooms and A&E departments full of victims of chesty coughs rather than car crashes – it's not pretty. But perhaps showing PCTs their worst-case scenarios is the only way to avoid pharmacists' own.

Jennifer Richardson
Features Editor

More enhanced services axed as PCT cutbacks spread to the north

Stop smoking and minor ailment services suspended or scaled back in north west England

Chris Chapman
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Pharmacies in the north west have seen services vanish or shrink, with two PCTs cutting minor ailments (MAS) or smoking cessation services.

Tameside and Glossop PCT has cancelled its smoking cessation service, and Blackburn with Darwen Teaching PCT will suspend its MAS through pharmacies from September.

East Lancashire PCT has also reduced its minor ailments service, with the formulary slashed and patients allowed only a limited number of visits before they must use GP services.

The cuts come just one week after C+D revealed the loss of a stop-smoking scheme in Surrey.

Lloydspharmacy director Andy Murdock hit out at the cuts, warning that PCTs were "cutting off their noses to spite their faces" with a narrow outlook.

He said: "If we are going to have greater efficiency in the NHS it would make sense to move treatment to the right place. In my view pharmacy is the best place [for minor ailments].

"If you look at the cost of pharmacy, it is cheaper. If you're increasing access, and doing it cheaper... it's a false economy [for PCTs to cut services]."

Ian Short, secretary for Oldham, Tameside and Glossop LPC, said the committee was considering whether to contest the loss of its the cessation service in its area. Pharmacy was a "soft target" that could see further cuts, he warned.

He said: "I deal with four PCTs and all are aggressively reviewing pharmacy services as they see bottom line quick savings. We're seen to be a particularly soft target."

However, Tameside and Glossop PCT offered a ray of hope, vowing it would try to save the service. Pharmacies had been so successful in helping quitters the service had outstripped its budget, the PCT said.

Mark Collins, PSNC north western regional representative, said the future of services through pharmacies in the region was "pretty much doom and gloom".

"The prospect of reduced income is really scary, and we've had to tell patients they can't use the service," he said.

However, Mr Collins praised pharmacist colleagues working in the PCT, despite the cuts.

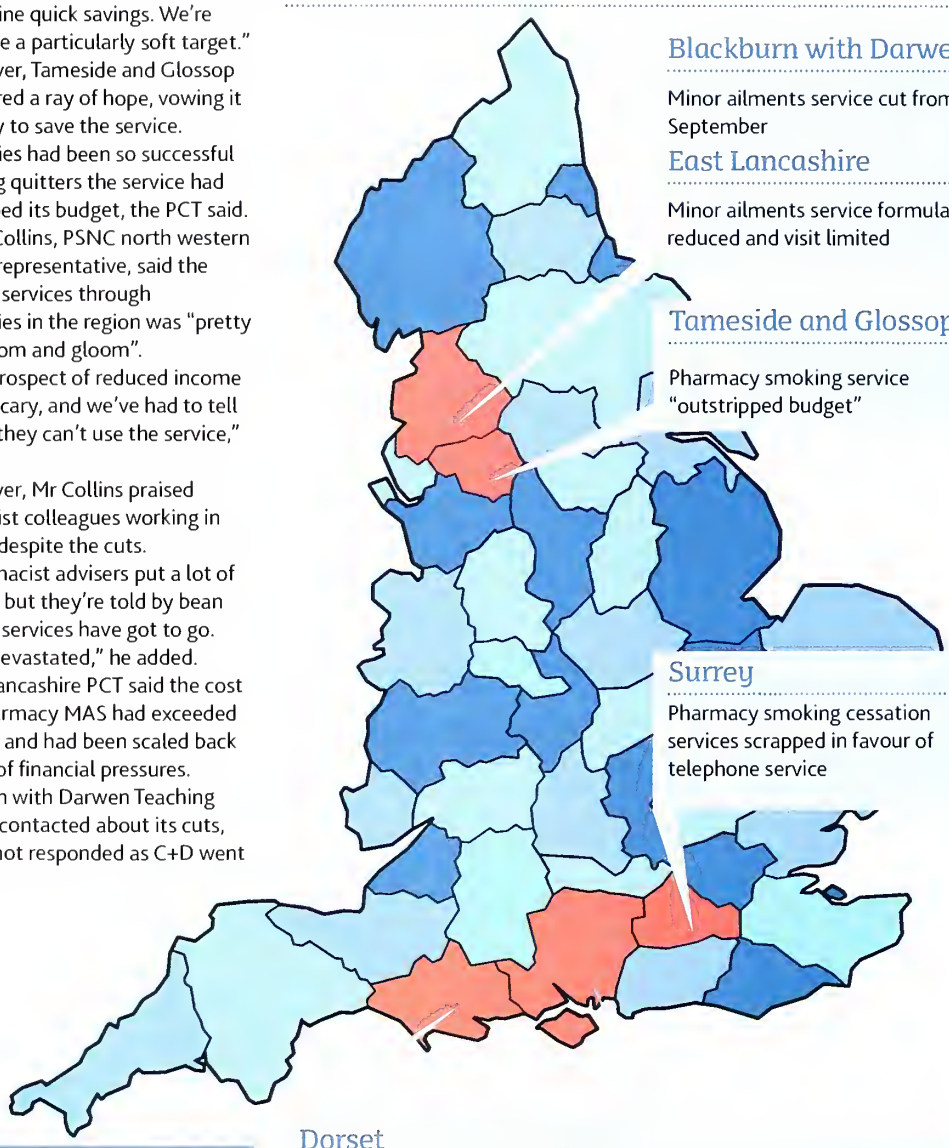
"Pharmacist advisers put a lot of work in – but they're told by bean counters services have got to go. They're devastated," he added.

Easy Lancashire PCT said the cost of its pharmacy MAS had exceeded forecasts and had been scaled back because of financial pressures. Blackburn with Darwen Teaching PCT was contacted about its cuts, but had not responded as C+D went to press.

MAS cuts will clog A&E and surgeries

More on PCT cuts page 8

Pharmacy services in England – the highs and lows



Blackburn with Darwen

Minor ailments service cut from September

East Lancashire

Minor ailments service formulary reduced and visit limited

Tameside and Glossop

Pharmacy smoking service "outstripped budget"

Surrey

Pharmacy smoking cessation services scrapped in favour of telephone service

Dorset

More than a third of patients who stopped smoking in 2009-10 did so through pharmacies

Hampshire

Pharmacists helped 2,087 patients quit smoking in 2009-10

PCT cuts beyond our control, warns PSNC

Service cuts are beyond the control of national pharmacy bodies, with PCTs basing the decisions on cost not evidence, PSNC has warned.

Speaking exclusively to C+D, PSNC head of NHS services Alastair Buxton warned the "hard and honest truth" was that there was "precious little" the committee could do to save services. "The best way forward in the medium to long term is to enhance the evidence base... but I don't think that's going to help as evidence isn't being used – it's what the PCT can afford to chop," he said.

PSNC had appointed a new staff member to collate the evidence base for pharmacy services, pulling together small-scale studies to create a national picture, Mr Buxton added.

English Pharmacy Board chair Lindsey Gilpin said the situation emphasised a "PCT postcode lottery", and that the RPSGB would lobby the Department of Health for support. She said: "We need to make it clear to the government the way isn't to abandon everything. This short-termism doesn't help. We need national guidance."

The national pharmacy bodies would be working together to look for solutions, Ms Gilpin added. **CC**

Pharmacies defy cuts to hit stop smoking targets

Hampshire and Dorset help thousands of patients to quit

Chris Chapman
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Pharmacies on the south coast are defying enhanced service cuts to see their stop smoking schemes thrive.

Pharmacists in Dorset were responsible for more than a third of the 2,328 patients who managed to give up smoking between April 2009 and March 2010.

Pharmacists in Hampshire were also celebrating success, having helped 2,087 of the 8,328 patients who quit in the county – 23 per cent over the PCT target.

Nationally, more than 750,000 people tried to give up smoking through the NHS in 2009-10, with almost 374,000 successful quitters at four weeks, the Department of Health said.

The government was currently reviewing how to move forward with stop smoking services, said health secretary Andrew Lansley. He said: "Smoking is the biggest preventable cause of death in England. We are now reviewing how best to tackle this issue in the context of the new priority and focus on public health by the government."

Last year around 81,400 deaths – 18 per cent of deaths in adults aged 35 and over – were estimated to be caused by smoking. There were around 1.5 million hospital admissions with a primary diagnosis of a disease that can be caused by smoking in 2008-09.

C+D fights for pharmacy on BBC Radio

C+D clinical editor Chris Chapman appeared on BBC Radio Surrey's breakfast show last week to hammer home the importance of stop smoking services through pharmacies.

Mr Chapman joined Surrey LPC secretary Martin Mandelbaum in warning patients would lose out due to the service withdrawal in the area. Mr Chapman said: "Still around one in five people in the country smoke... we really need to help these patients to give up as an NHS goal for public health."

NHS Surrey told the BBC the pharmacy enhanced service was "not good value for money", and a phone support scheme had proven more cost effective and efficient.

To listen to the interview, go to **www.chemistanddruggist.co.uk**

Senate urges rethink in errors fight

Guidance produced on single dispensing errors by the Crown Prosecution Service (CPS) does not go far enough in protecting pharmacists, the C+D Senate has concluded.

But rather than just pushing for a law change, which could be a lengthy process, the profession should focus on reducing errors and could lobby the attorney general, the Senators agreed.

Senator and lawyer David Reissner said although the CPS guidance was designed to make prosecutors think twice about bringing cases against pharmacists, all it had done was to restate the code for deciding whether to prosecute.

"But that code was in place at the time Elizabeth Lee was charged," he warned. "If prosecutors now were brought under pressure by families or by police there is no reason to suppose the situation would be particularly different."

Pharmacists agreed they did not feel protected by the guidance and Mr Reissner continued: "I would make representations to the attorney general who is responsible for the CPS. I would say that this statement doesn't do the job and then say I wanted the CPS to say it wouldn't bring a prosecution without consulting the regulator."

Mark Koziol: CPS guidance gives defence teams "more to get their teeth around"

Senator Mark Koziol of the Pharmacists' Defence Association said the guidance did give defence teams "more to get their teeth around", but agreed prosecutions could still happen.

The Senate also called for a culture shift to encourage error reporting and said pharmacists must make reducing errors a priority. Rowlands Pharmacy area manager and Senator Debby Crockford concluded: "If humans are involved there are always going to be errors and the only way to improve practice is to self-report those."

The Senators discussed the Elizabeth Lee case after C+D readers unanimously voted for the topic to be on the agenda at the C+D Senate. **ZS**

The full verdict on dispensing errors

More on the Senate page 22

In brief

Tesco's super Price

Adrian Price has joined Tesco as superintendent pharmacist. Mr Price, formerly Co-operative Pharmacy clinical commercial manager, replaces Penny Beck, who has taken early retirement.

Boots service pilot

A Boots pharmacy in the centre of Edinburgh has launched a range of walk-in services as part of a Scottish Government pilot. The multiple has teamed up with NHS Lothian to offer services ranging from nurse-led minor illness and injury treatment and sexual health advice to simple diagnostic healthcare checks and tests.

AZ strikes: no impact

Strikes at AstraZeneca's major UK manufacturing site will have "minimal" impact on medicines supply to pharmacies, the pharmaceutical giant has said. This week union GMB announced three dates of strike action during September.

Read more on the above stories at **www.chemistanddruggist.co.uk**

Non-emergency? Dial 111

A new telephone number for non-emergencies has been launched in north east England. The 111 service, which is being piloted in Durham and Darlington, offers medical advice and signposting to pharmacies. The service will be rolled out to Nottingham, Luton and Lincolnshire later this year.

Dronedarone for AF

Nice has recommended dronedarone as a second-line treatment for patients with AF not controlled by first-line therapy, who have additional cardiovascular risk factors. Last year a meta-analysis found the drug was less effective at preventing AF recurrence than amiodarone, but had fewer side effects.

Migraine aura mortality

Patients who suffer migraine with aura are at increased risk of all-cause mortality. Reporting in the BMJ, researchers from Iceland found patients with migraine without aura were not at increased risk.

Video: Teva introduces its generic OTC range
www.chemistanddruggist.co.uk

Tutor avoids striking off over exam fixing incident

De Montfort academic 'put under pressure' to inflate students' marks

Max Gosney
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A pharmacy tutor who fixed exam papers to ensure students passed can carry on practising as a pharmacist, the RPSGB disciplinary committee has ruled.

Janet Eden, a former tutor at De Montfort University, received a warning as the panel acknowledged the "exceptional" nature of her case.

In May 2007, Mrs Eden doctored the papers of seven students taking a microbiology and biotechnology exam to help them hit pass marks.

The incident followed pressure and hostility from colleagues, the disciplinary meeting heard.

Mrs Eden, of Leicester, had previously denounced a move by De Montfort University in 2004 to boost students' marks to increase pass rates.

Mrs Eden had told colleagues they "had all gone mad" to consider inflating marks, according to a statement by Joan Taylor, professor of pharmaceutics at De Montfort.

Mrs Eden was "publically humiliated in the most grotesque way" in the meeting and began to "crumble over the next two years", according to Professor Taylor.

Three years later, Mrs Eden said she had been told by a colleague of his "disappointment in my marks" on seven borderline papers. These were "considerably lower" than those of two other academics, Mrs Eden said she was told.

"I distinctly remember returning to my desk after the meeting with the thoughts in my head that... if he wanted the marks altered, he will get them altered," Mrs Eden told the committee.

Mrs Eden had made a full confession at the earliest possible moment, the committee acknowledged.

The panel also recognised the incident was a single blemish in a 35-year career.

Panel chairman Patrick Milmo QC said: "We think there has been full insight into the enormity and seriousness of what she did."

The panel stressed conduct involving dishonesty should be regarded as the highest level of misconduct and usually attracted a striking off or suspension.

But, Mr Milmo concluded: "We are convinced there is no prospect at all of repetition as she has no intention of returning to the academic world and in our view there is no realistic prospect of any dishonest or similar conduct being committed by her as a locum pharmacist."

NCSO update

The Department of Health and National Assembly for Wales have agreed to allow NCSO endorsements for the following items for August prescriptions: ofloxacin 400mg tablets.

Lloydspharmacy pre-reg

Lloydspharmacy has partnered with an NHS Foundation Trust to create a pre-reg programme that includes placements in community and hospital pharmacy. Under the scheme, two trainees will work for six months in each organisation.
www.chemistanddruggist.co.uk

Colic medicines shunned

Nearly two thirds of health professionals are very concerned about giving medicines to young babies to ease colic symptoms, according to research. More than half of the 253 respondents said that they would prefer to advise patients to switch feeding bottles instead, market research company Consumer Analysis said.

Sex ed essential

The Faculty of Sexual and Reproductive Health has called for sexual health services to become a public health priority. The comments came in response to Office of National Statistics data that showed a small rise in teenage pregnancies over the past quarter.

Blood pressure test bid

More than 1,400 pharmacies, supermarkets, shopping centres, workplaces and community venues will set up blood pressure stations as part of the Blood Pressure Association's Know Your Numbers Week. The event takes place from September 13 to 19 and aims to tackle poor awareness of blood pressure among adults.
www.chemistanddruggist.co.uk

GP systems firm buys Rx Systems

Pharmacy software and services company Rx Systems has been bought by EMIS, the UK's largest GP systems firm, in a £10 million deal.

The acquisition gave the potential for greater integration between pharmacy and GP IT systems, EMIS told C+D.

A spokesperson for the company said: "It is too early to say in detail how we will develop the integration between the EMIS GP systems and the ProScript system.

"However, there is clearly potential to enhance the message flows between the patient, GP and pharmacist – including EPS message flows – and this is something we will be actively investigating in the coming months."

The company added that it could anticipate future integration of EMIS and Rx Systems technologies that could enable further streamlining of electronic prescription services.

The deal could see more integration between pharmacy and GP IT systems

Rx Systems currently has a 20 per cent share of the community pharmacy market, with 2,500 community pharmacies using the company's ProScript dispensary management system.

Further growth could be achieved following the acquisition, according to EMIS.

The acquisition is also important for the provision of 'joined-up' healthcare for NHS patients, the company said. **HF**

Cegedim Rx gets EPS2 approval from Department of Health

See page 10

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NHS to foot the bill from MAS cutbacks

Patients would swamp costly GP and A&E services, LPC survey finds

Chris Chapman
chris.chapman@ubm.com

A national minor ailment scheme could save the NHS more than £2 billion a year

Eight out of 10 patients accessing minor ailment services (MAS) would go to a GP rather than pay for their medicine if the service was cut, a survey has found.

The week-long survey by East Lancashire LPC saw 36 pharmacies ask minor ailment patients where they would go if the pharmacy did not offer the MAS scheme.

Of the 376 patients asked, 312 (83 per cent) said they would access their GP rather than a pharmacy. Only 23 per cent of those asked said they would buy a product, with 25 (7 per cent) saying they would have gone to A&E instead.

One respondent said they would go to A&E for their chesty cough because they could never get an appointment with their GP.

According to the Self Care Campaign, which aims to reduce GP consultations for minor ailments, a visit to a GP costs the NHS £32, a visit to A&E £111 and self-care up to £3.50.

According to these figure, the 36 pharmacies saved the NHS £12,169.25 during the study period – around £17,650 per pharmacy every year, or more than £2 billion per year if the scheme were adopted nationally. The findings come as PCTs across England cutback on pharmacy MAS (C+D July 24/31, p5).

Dr Paul Stillman, a Sussex GP and member of the Self Care campaign, said the results showed pharmacists could help treat patients and keep NHS costs down.

Clinical debate **C+D's Chris Chapman looks at the evidence behind the headlines**

We can't afford wait in STI war

The latest statistics on sexually transmitted infections in the UK are just stunning. There is simply no other word for it. And it's a problem that means pharmacists have their work cut out.

According to data from the Health Protection Agency released this week, there were 482,696 diagnoses of an STI in the UK in 2009 – up 12,000 on 2008. Two thirds of diagnoses in women were in those under 25; for men, just over half. The peak age for an STI in the UK is now between 19 and 20 for men, and 20 to 23 for women.

In terms of geography, STI hotspots include London, Brighton and Hove, Nottingham, Manchester and Southampton. Men who have sex with men remain an at-risk population, with high rates of STIs reported in this group.

To my mind, one of the most worrying statistics is the reinfection rate. One in 10 under 24-year-olds diagnosed with an STI will become reinfected within a year. This figure serves to emphasise not only how important chlamydia screening is as an enhanced service, but how important it is to get the safe sex message to young people. Tips are available at www.chemistand druggist.co.uk/cpdzone.

Another ominous statistic caught my eye. Rates of gonorrhoea in the UK increased by 6 per cent compared with 2008, up to 17,385 cases. Worse, resistance to cefixime, the first-line treatment, has increased from one in 1,000 cases to more than one in 10 in just four years.

Bacterial resistance is an unfortunate reality for all conditions requiring antibiotics. But unlike the war against the likes of staph and strep, the transmission of gonorrhoea is easily preventable. The statistics show the vital importance of safe sex education, especially in young people and men who have sex with men. We need to make sexual health a public priority now – otherwise we may find ourselves facing an epidemic without the arsenal of drugs we need.

To discuss this subject in private with your pharmacy colleagues, join the debate in C+D's Linkedin group at www.linkedin.com – search for Chemist and Druggist.

Chat with Chris on Twitter: www.twitter.com/CandDChris

Psoriasis Treatment advice for pharmacists

Feel it. Treat it. Control it.[1]

Now is the time when patients may feel more self-aware about their psoriasis, as clothing switches to summer fashions.

Consequently, more people may be seeking advice from healthcare professionals about how best to treat their condition.

POOR PATIENT COMPLIANCE

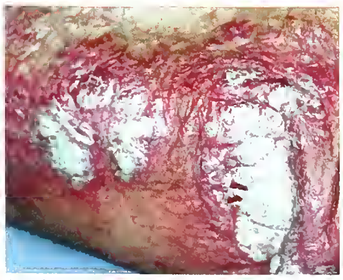
49% of patients with psoriasis do not fully comply with their treatment[2], so it's important to recommend a therapy that patients can believe in when they feel their condition flare up.

EFFECTIVE TREATMENT CAN HELP

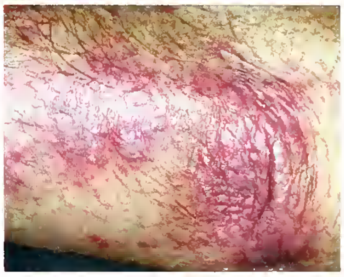
Once daily DOVOBET® has been shown to deliver fast and effective psoriasis therapy.[1] In fact, DOVOBET® is more effective than either a steroid alone† or calcipotriol alone[1†], helping to build confidence, encourage patient compliance and ultimately promote treatment success.[3]

DOVOBET® is well tolerated[4] and under medical supervision can be used for treatment beyond 4 weeks as required.

PHARMACY HELP AND ADVICE



Before treatment*



After 6 days treatment with DOVOBET®*

B.A.D guidelines encourage a greater patient involvement with their treatment plan.[5] Doctors are therefore advised to review their new patients after 4 weeks to assess progress and ensure that patients correctly understand how and when to use their treatment.

To help with this process, LEO has produced a patient information pad that GPs and pharmacists can use when a patient has been prescribed DOVOBET® ointment.

HELP TO MANAGE PSORIASIS IN THE COMMUNITY

It has been shown that when used 1st and 2nd line, DOVOBET® can also help reduce the need for secondary intervention (referrals, phototherapy, systemic therapies and biologics), with potential savings of more than £55,000 for an average general practice over 2 years.**[6]

With recommended use of emollients in-between flare-ups, good advice and effective treatment can help control psoriasis in the community.

† In combination base ... These pictures are illustrative ... based on a practice of 10,000 patients ... Savings based on difference in cost of ... calcipotriol plus steroid 2nd line.

The trials of buying a pharmacy – read Ravi's blog
www.chemistanddruggist.co.uk

Dispensary talk

Should non-pharmacists be able to join the PLB?

"Yes they should be allowed to join as we are increasingly trying to encourage as much integration as possible, and having technicians registered with the PLB would serve us well."
Stephen Foster, Pierremont Pharmacy, Broadstairs, Kent

"Yes and no. I think yes because it is good to get an opinion from people outside of pharmacy, and no because people who are not pharmacists don't really understand how pharmacy works."
Elaine Tang, Co-operative Pharmacy, Hyde, Cheshire

Web verdict

Yes 19%

No 81%

Armchair view: Pharmacists are not keen to share the professional leadership body, according to C+D's survey. More than four out of five respondents reported they did not think non-pharmacists should be able to join the body.

Next week's question:
Has your PCT cut any enhanced services in the past month? Vote at **www.chemistanddruggist.co.uk**

GPhC fails to justify fee rise plans, says RPSGB

We don't want war, but increases must be challenged says Society

Max Gosney
max.gosney@ubm.com

The RPSGB has blasted the GPhC for hiking up fees without proper justification.

Costs were "contradictory" and "hard to justify", the RPSGB national boards said in response to proposed fees for the new regulator.

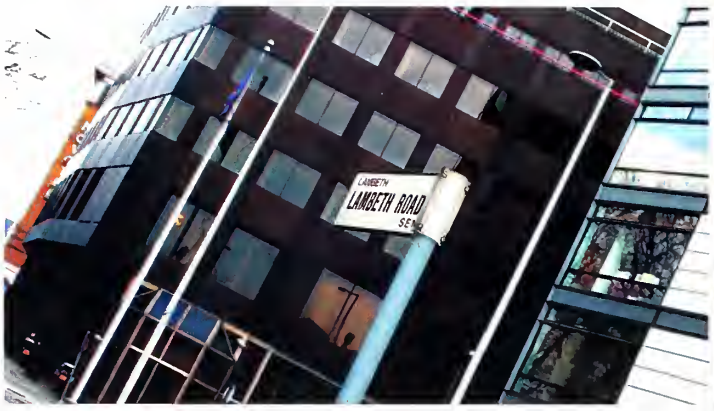
The GPhC was also accused of breaking a promise on keeping retention fees down. The Society stressed the criticism was intended as a "robust challenge" on behalf of pharmacists and not an act of war.

Graham Phillips, member of the English Board, told C+D: "The GPhC is asking for money on top of more money. But there is a complete lack of information explaining why."

He added: "The GPhC has presented itself as an open and transparent regulator; it needs to demonstrate that from the start."

Instead, rises had been made against an "assumed" increase in regulatory costs, the RPSGB said.

Mr Phillips said the GPhC's proposed £262 retention fee was a key concern. The sector was promised in 2008 that combined fees for the new regulator and professional leadership body (PLB) would not exceed £395. The GPhC's proposed levy means the combined fees break the cap by £59.



The RPSGB is accusing the GPhC of breaking a promise to keep retention fees down

Mr Phillips acknowledged the promise on fees was first made by former RPSGB chief executive Jeremy Holmes. But he stressed the government had committed to the set up of a PLB and should provide full financial support.

A proposed rise in attendance fees for GPhC activities and committees also drew fire from the Society. This signalled a 27 per cent hike against current RPSGB levies, it said.

The comments came as part of the RPSGB boards' response to a GPhC consultation on fees that closed last week.

The GPhC declined to respond to the criticism. GPhC chief Duncan Rudkin has previously stressed the regulator cross-checked against RPSGB fees to inform its proposals.

Has the GPhC set fees too high?
max.gosney@ubm.com

EPS rollout boosted with Cegedim Rx approval

Cegedim Rx has completed the approval process for release 2 of the electronic prescription service (EPS) with its Pharmacy Manager system.

The supplier has successfully completed the initial implementation phase and been given approval to start rolling out the system more widely. Initially it can install the system in up to 200 pharmacies.

The Department of Health (DH) announced Cegedim Rx had passed the standard assurance process for introducing the system into a limited number of pharmacies across England.

A DH spokesperson said this would ensure safe and steady progress was made and that Cegedim Rx had the capacity to successfully deliver, while increasing patient safety and efficiency, the spokesperson added.

Cegedim Rx managing director Simon Driver said: "It's good to see significant progress with EPS as release 2 has the potential to deliver significant administrative and clinical benefits. Cegedim Rx will work closely with NHS Connecting for Health to identify the milestones and logistics of the next stage of the limited deployment."

Other systems currently expected to be given rollout approval in 2010 include ProScript Link and ProScript.

Nexphase and Positive Solutions' Analyst PMR/Integrated PMR and EPOS 1.11 are also predicted to begin and complete initial implementation in the last three months of the year. **ZS**

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Phoenix Code: 8897209
Alliance Code: 8101065

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Mckenzie House, Bury Street, Ruislip, Middlesex, HA4 7TL, UK.
Telephone: 01895 627 420, Fax: 01895 631 777, E-mail: info@audenmckenzie.com

PLEASE CONSULT THE SUMMARY OF PRODUCT CHARACTERISTICS BEFORE PRESCRIBING.

ABBREVIATED PRESCRIBING INFORMATION
Presentation: Audmonal™ 60mg Capsules and Audmonal Forte™ 120mg Capsules Indication: Adjunct in gastro-intestinal disorders characterised by smooth muscle spasm, such as irritable bowel syndrome, painful diverticular disease of the colon and primary dysmenorrhoea Dosage and Administration: Adults and Children over 12 years, 60-120mg 1-3 times daily Contraindications: Paralytic ileus Undesirable effects: Nausea, headache, dizziness, pruritus, rash, hepatitis also reported Legal Category: P PL 17507/0148/0149
MA Holder: Auden Mckenzie (Pharma Division) Ltd, Telephone 01895 627 420. All information correct at date of publication: August 2010. Ref: NPD-LNCH08-10/AUD60-120.

Auden Mckenzie
(Pharma Division) Ltd

Dexamfetamine Sulphate 5mg Tablets

As of 31st August 2010
DEXEDRINE 5MG TABLETS
will be **DISCONTINUED** and replaced by
Dexamfetamine Sulphate 5mg Tablets

Available from all major Wholesalers from 1st September 2010

Dexamfetamine Sulphate 5mg Tablets (x28)
PIP Code: 115-6348
AAH Code: DEX0423G
Alliance Code: 8102444
Phoenix Code: 8898603

For further information contact: Auden Mckenzie (Pharma Division) Ltd.,
Mckenzie House, Bury Street, Ruislip, Middlesex, HA4 7TL, UK.
Telephone: 01895 627 420, Fax: 01895 631 777, E-mail: info@audenmckenzie.com

Auden Mckenzie

PLEASE CONSULT THE SUMMARY OF PRODUCT CHARACTERISTICS BEFORE PRESCRIBING

ABBREVIATED PRESCRIBING INFORMATION
Presentation: Dexamfetamine Sulphate 5mg Tablets Indication: Narcolepsy, Refractory ADHD (under specialist supervision) Narcolepsy, 10mg daily in divided doses, max ol 60mg daily Refractory ADHD, Adults 5mg twice daily, max ol 60mg daily Child 6-18 years, 5-10mg daily, max 1mg/kg (up to 20mg) daily Cardiovascular disease including, structural cardiac abnormalities, advanced arteriosclerosis, hyperexcitability, hyperthyroidism, history of drugs or alcohol abuse
Special warnings and precautions: Caution required in patients with anorexia, hypertension, psychosis or bipolar disorder, tics and Tourette syndrome, monitor growth in children, angle-closure glaucoma, avoid abrupt withdrawal, acute porphyria Undesirable effects: Insomnia, irritability, confusion, dependence and tolerance, gastro-intestinal symptoms, tachycardia, myocardial infarction hypertension, visual disturbances, cardiomyopathy Contains Lactose and Sucrose

Legal Category: POM/CD PL 17507/0188 MA Holder: Auden Mckenzie (Pharma Division) Ltd Telephone 01895 627 420 All information correct at date of publication: August 2010
Ref: NPD-LNCH08-10/DXFT5

Auden Mckenzie
(Pharma Division) Ltd

New name for Corlan pellets

Auden Mckenzie is renaming Corlan pellets, as Hydrocortisone 2.5mg Muco-Adhesive Buccal Tablets, from September.

Hydrocortisone 2.5mg Muco-Adhesive Buccal Tablets are indicated for the treatment of mouth ulcers and work by reducing swelling and inflammation in the mouth, according to the company.

The product is available from AAH Pharmaceuticals, Alliance Healthcare, Phoenix and Sigma Pharmaceuticals.

Price: £3.79/20
Pip code: 115-6652
Auden Mckenzie (Pharma Division)
Tel: 01895 627420
info@audenmckenzie.com

Woundcare gel spray now available from Niche Generics

Niche Generics has announced the launch of Flamizol Hydrocolloid gel spray.

Flamozil is a paraben-free hydrocolloid gel that uses silver citrate as a preservative, says the company. The product is indicated for the care of local, dry or moist wounds and indirectly promotes wound healing by regulating the microenvironment of the wound, Niche Generics adds.

Prices and pip codes: See C+D Monthly Price List or www.cddata.co.uk
Niche Generics
Tel: 01462 633800

Superdrug launches 'virtual mirrors' for cosmetics clients

Superdrug is trialling 'virtual mirrors' that help customers choose cosmetics, in two stores.

The mirrors allow customers to take photographs of themselves and use the touch screen to 'apply' cosmetics and experiment with different colours and strength of shades, free of charge.

After taking a photograph using the inbuilt camera, customers can pick up a product from the stand in which the unit is contained (GOSH or Rimmel), scan the product and then the computer will 'apply' the product to the image.

Customers can then email the images to their personal account, Facebook or Twitter pages, which will give them a record of the products they selected.

The units are installed in Superdrug stores in Westfield, London and Meadowhall, Sheffield.

Market focus: Dos and don'ts for headlice

Nurse and headlice expert Christine Brown offered some dos and don'ts for headlice, at the launch of Hedrin Once last week

Do make sure parents use the treatment correctly. Hedrin Once needs to be used once but some treatments need to be used twice, with each application a week apart.

Don't provide headlice treatment unless you are sure there are lice present. Ask customers to bring in a louse stuck to a piece of sticky tape.

Do suggest parents check their children's hair once a week, and again two to three days after treatment if they require it.

Don't support the use of electronic combs, or 'alternative' treatments that have not been shown to be effective.

Do nominate a member of staff to provide up-to-date information to customers about headlice.

Don't encourage repeat use of treatment unless you are certain reinfection has occurred.

Do suggest the whole family gets checked if headlice are found.

CPD ZONE
How to make the most of the £25 million headlice market
www.chemistanddruggist.co.uk/cpdzone

On TV next week

Hedrin: GMTV, five, Sat
Magicool: GMTV, five, Sat
Magicool Plus: GMTV, five, Sat
Panadol: All areas
Savlon: All areas
PharmaSite for next week: Pond's Cold Cream – windows, **Pond's Cold Cream** – in-store, **Propain** – dispensary

A-Anglia, B-Border, C-Central, C4-Channel 4, five-Channel 5, CAR-Carlton, CTV-Channel Islands, G-Granada, GMTV-Breakfast Television, GTV-Grampian, HTV-Wales & West, LWT-London Weekend, M-Meridian, Sat-Satellite, STV-Scotland (central), TT-Tyne Tees, U-Ulster, W-Westcountry, Y-Yorkshire

Letters

Memoirs of a crime-fighting pharmacist

Reading C+D's exposé of the crime wave against London pharmacies (C+D, Aug 14, p6) reminded me of my own brush with the criminal underworld.

When I was a young, fit, 23-year-old pharmacist, I literally took my life in my hands to manage probably the most dangerous pharmacy in London at that time. The previous manager was severely injured and needed stitches after attempting to apprehend thieves.

I was an assistant junior instructor and former junior county and southern area judo champion at the time. One morning a guy came in with a forged private prescription. I asked him to leave, at which point he swung a big right cross. I grabbed his fist, held him in a standard judo ground hold, applying an arm lock and stranglehold simultaneously.

The old ladies in the pharmacy gave me a standing ovation. I later got a call from the surgery saying that the violent patient had returned and managed to assault one of the GPs.

On another occasion, I had to eject a violent customer who threatened to burn down the pharmacy. Normally guys who threaten don't act. Well, that rule definitely went out of the window: two weeks later I got a call from my boss saying that the pharmacy was on fire and it's all my fault!

Another memorable moment involved a 6ft 2in burly biker. He presented a forged prescription and, to my dispenser's amazement, I invited the biker into the back room. I told him to take a seat before saying: "By the way you are nicked! I must warn you I am a judo expert, but if you don't give me any trouble you won't get hurt."

The biker could not believe my audacity and actually sat down and made no attempt to escape.

I phoned the local police station, who were open-mouthed in amazement. Within five minutes, two squad cars turned up with six excited young police officers. They were running around the pharmacy asking where he was.

At that point he was just making his getaway. So I approached him from the rear, and grabbed him in a sumo grip around the waist. He couldn't move and the police handcuffed him. The next afternoon I was guest of honour for lunch at the local police station; I also got a commendation for bravery.

I knew I was taking unnecessary risks and at that point was married with a child on the way. I knew it was time to move on.

My career in community pharmacy only lasted for six years in the end. I nearly gave my last boss a heart attack. He used to say: "Gary, if you wanted to be a cop why didn't you?" He wasn't happy but I managed to squeeze in six citizens' arrests, mostly for forged prescriptions; we even had a stake-out in the pharmacy.

Would I do it all again? Yes, if I could sort out my back injury and lose 30lb. But, seriously, do not try this at home, folks. However, I do have some top crime fighting tips:

- If you are working in a dangerous area, make sure there is a security barrier between you and the public
- Get a security guard if you can afford one
- Make sure you get regular high profile visits from local police
- Make sure you have a panic button to the local police station
- If confronted by a criminal then stay calm and stick together
- Never open or close the pharmacy on your own – this is when you are most vulnerable.

Gary Lewis, managing director, A1 Pharmaceuticals

Contact us

Email your letters, including your name, address and contact number, to **haveyoursay@chemistanddruggist.co.uk**

Mutton dressed as lamb

"WHAT IS A CHEAP AND QUICK WAY OF MAKING MONEY? MARKET YOUR OLD PRODUCT IN A NEW WAY. OR IN OTHER WORDS – RANGE EXTENSION"

I heard on the news that insurance fraud is on the increase. I suppose that as work dries up, people turn to whatever they can think of to bring in money, and necessity is not always the mother of a good invention. But a big company can't burn its factories and make a claim, so what's a multinational to do when times are hard? Let me tell you a story.

There was an old Victorian pharmacy called Ye Olde Penny Dreadful that produced its own Cold Cure and Cod Liver Oil. These were marketed so well that by the late 19th century, Penny Dreadful Cold Cure and Penny Dreadful Cod Liver Oil were on the shelves of every pharmacy and supermarket in the country.

These products had become market leaders, but shareholders of Ye Olde Penny Dreadful plc were demanding ever greater profits. This was a problem because they had saturated the market, and couldn't make people buy any more Cold Cure or Cod Liver Oil. They couldn't patent a brand new treatment because, well, everything easy has been invented and besides – it takes too long and costs too much money. So what is a cheap and quick way of making money? Market your old product in a new way. Or in other words – range extension.

So they started with New – Full Strength Cold Cure and Single Dose Cod Liver Oil, which they said appealed to a younger market, and so the advertising showed people with iPods taking Penny Dreadful Full Strength, or skateboarders using Penny Dreadful Single Dose CLO to keep their knees supple. It sold well. Retailers smiled, Penny Dreadful plc smiled, and everyone was happy.

The following year they introduced Junior Cold Cure as well as Cod Liver Oil "with Multivitamins", "with Orange and Mango", and "with Probiotics". Of course, with each extension to the range there was big press and TV advertising of these "new" products. Having created such a demand, they then sold millions of cases to the wholesalers, who in turn sold them to the poor pharmacists who had to stock it, and at last count there were 50 lines in the Penny Dreadful range. By now pharmacy had space for nothing else on the shelves.

And the moral of this story? There's only so many range extensions you can bring out before retailers will rebel against this lazy form of business, because the public are only going to spend their diminishing disposable income on something genuinely new.

And you must engage with pharmacy to develop a new market, which at least is what Teva looks to be doing (C+D, August 21, p14). They are hoping to persuade the public to "trade down" from the premium product to generic, and it might just work, since the only high street stores seeing record increases at the moment are the pound shops. If we can only find some shelf space...

Are there too many product range extensions?

haveyoursay@chemistandruggist.co.uk

Nick Barber

Medicine adherence – just a phone call away

Ever had this experience: you buy a new camera, smartphone or other piece of technology and, a couple of weeks later, you still can't make it do some of the things you want. It is really frustrating, and you get a bit fed up with it. Now, imagine that the person who provides you with this technology contacts you a couple of weeks later and says: "How are you getting on? Have you got any problems? Here is how to make it do what you want." Would you buy from them again? I bet you would. Some of us, cash-rich and time-poor, would probably pay for the advice.

So why don't you do it with the medicines you dispense?

Some years ago I had been working with specialists in the usability of technology, studying computerised dispensing systems, when it finally struck me – in a Homer Simpson-like 'D'oh' moment – that medicines are technologies, too, and that perhaps a significant part of non-adherence was a usability issue. I pulled together a team, and we showed that many patients struggled with medicines soon after starting on them.

We found that, in patients who had just started a new medicine for a chronic condition, a phone call from a pharmacist after a couple of weeks was immensely helpful. Non-adherence was halved, and the number of reported problems was significantly reduced; and all for a phone call, which lasted an average of only 12 minutes. Even better, when we followed up patients for several months and conducted an economic analysis we found that this new service was more than 90 per cent certain to be more cost-effective than normal care.

Now, as an academic, I am of course officially useless. So I was delighted when this research became a recommendation in 2008's pharmacy white paper. I was even more delighted when I found that funding negotiations were in progress. I was not sure whether this would be scuppered by the new government; however, at a reception at the House of Lords, Earl Howe specifically mentioned this work as something they would look at continuing. The recent report in C+D (July 24/31, p14) suggests that the service may be funded.

What I remember most about the service is how powerfully some simple suggestions and information affected patients' lives. It was really fulfilling for the pharmacists, as well. Surprisingly few patients start a new medicine for a chronic condition, perhaps one or two a day at a typical pharmacy. I hope many of you will take up this new service; I do not think you will regret it.

Professor Nick Barber, Centre for Medication Safety and Service Quality, The School of Pharmacy, University of London

"IT STRUCK ME – IN A HOMER SIMPSON-LIKE 'D'OH' MOMENT – THAT MEDICINES ARE TECHNOLOGIES, TOO"

Letters

Email your letters to haveyoursay@chemistanddruggist.co.uk

Victorian parallels

Like many pharmacists I have watched with interest the endeavours of Professor Nick Barber in BBC2's Victorian Pharmacy show. The feeling I take away from each episode is inevitably a sense of pride, but also wonder at the journey of the profession.

Interestingly, the number of parallels that exist today also impress – regulation vs professional freedom; the role of pharmacists in public health and in championing the needs of those who cannot or choose not to access a doctor.

My pharmacy was established in 1790, 40 years before the setting of the first programme. I can't help but feel that pharmacy is less interesting than in the days of wet chemistry and firework-making!

The interesting part of the programme for me is in the direct comparisons to modern pharmacy, in particular the role that pharmacy played in developing the first antiseptics. When ordinary people could not afford to access a doctor it was pharmacy to which they turned for health advice. The direct parallel these days is to people who are not registered with a GP, who will be completely disenfranchised by GP commissioning – it is this group that pharmacy should be in a position to champion.

Public health is another key area where the Victorian pharmacist lit the way – improving sanitation; getting people to stop smoking, eat less, exercise more and drink less – and there is something very Victorian in those values. Interestingly, Anna Dixon, head of policy at the King's Fund, recently noted that GPs have largely failed to address health inequalities in favour of achieving QOF points.

This will become a key territory under GP commissioning arrangements as GPs will not control the public health budget – being cynical you could read this as extra money for GPs as it may sit outside of their budgets. However, pharmacy has walk-in convenience up its sleeve on this issue.

We cannot allow government to see general practice as the panacea for public health – pharmacy has just as important a role, and sees many more people every year.

Mike Hewitson, Beaminster Pharmacy, Dorset

Update

Your weekly CPD revision guide
Module 15

60-second summary

Why read this article?

A range of oral nutritional supplements (ONS) is available. However, ONS cannot be treated as simple foodstuffs, as they can affect the pharmacology of drug treatments and there may be interactions. Patients who do not require their ONS or dislike the flavours prescribed may stockpile the products, and alternatives may be indicated.

How widely do ONS products vary?

ONS vary widely in composition; some are nutritionally complete, others are in a concentrated form suitable for patients able to swallow small amounts only, while others are high in micronutrients or contain fibre. As well as varieties of flavours, ONS products are available with a selection of textures, which can help reduce taste fatigue. Pre-digested ONS products may be suggested for individuals with maldigestive states.

What are the issues in dispensing ONS?

Patients are likely to be taking other medicines so interactions need to be considered. Pharmacological interactions with ONS are varied, and can include the effects that the ONS may have on other prescribed medications and vice versa.

Adult oral sip supplements

A community pharmacist's guide to ONS products

Peter Austin MRPharmS

What is malnutrition and why take an interest in it? The 2006 Nice adult nutrition support guidelines define an adult who is malnourished or who is at risk of malnutrition. The criteria (see table 1, below right) are based on those of the Malnutrition Universal Screening Tool. Obese patients may be either malnourished or at risk of malnutrition within these criteria.

Many individuals with a poor nutritional state will be elderly and/or have co-morbidities. Around 10 per cent of free-living and 30 to 40 per cent of elderly patients in care homes will have, or be at risk of, malnutrition.

A poor nutritional state resulting from inadequate intake by any route can lead to complications, and nutrient deficiencies lead to functional compromises that may not be immediately obvious (see table 2, opposite page). In addition, the indirect consequences of these various complications and compromises limit the individual's ability to effectively deal with other co-morbidities they may have.

The importance of nutritional state to clinical outcome, and the significant annual expenditure on nutrition products, means that this is an area of interest to all pharmacists.

Use of sip supplements

Oral nutritional supplements (ONS) are used to improve the nutritional intake of patients who have a safe swallow but who are unable to meet their needs from a normal or otherwise supplemented diet. ONS should be continued until the patient can demonstrate an adequate intake from normal food. Their use is typically short term (weeks to months) but there may be cases where they are required for much more extended periods. Sip supplements would not usually be expected to be the sole source of nutrition and therefore the concurrent use of ONS with other nutritional intake is perfectly acceptable to meet the overall needs of the patient.

Types of sip supplement

The most obvious variation in ONS is the nutritional completeness of the product. This is relevant because the provision of protein and energy alone does not meet the complete nutrient requirement for cellular growth and repair, so in some cases an improvement in body function could be expected without an associated improvement in weight gain. A 'complete' sip feed contains a full range of nutrients that would, in theory, be able to effectively provide an individual's complete nutritional requirement. The volume required depends on the specific ONS content per unit volume and on the requirements of the patient.

A wide range of ONS is available, including those that are 'complete' at a lower volume. These are used for patients with a more limited fluid requirement, or who are unable to tolerate higher volumes of ONS but can ensure an adequate intake of fluid from another source if necessary. Other ONS may, for example, have a greater micronutrient content per unit volume, or contain fibre to meet different clinical needs.

Complete ONS have a fat component that provides essential fatty acids. Some patients find this type of supplement more palatable if diluted with milk immediately before consumption or if they are used in a variety of recipes – they can, for example, often be mixed with coffee or included in cakes. A variety of recipes is available from the manufacturers. As well as a variety of flavours, the texture of ONS can offer a further variation to limit taste fatigue, such as a tangy yoghurt-style.

The fat component of ONS is sometimes replaced with a greater carbohydrate component

Table 1: Nice adult malnutrition definitions

Malnourished

- Body mass index (BMI = kg/m^2) of less than 18.5, or
- BMI of less than 20 with unintentional weight loss of more than 5 per cent over the preceding three to six months, or
- Unintentional weight loss of more than 10 per cent over the preceding three to six months

At risk of malnutrition

- More than five days with a poor nutritional intake, or
- Specific nutritional needs due to poor absorption, high losses or increased needs

Note: definitions should always be considered in clinical context

Table 2: Effects of malnutrition

More obvious effects

- Poor vision (vitamin A deficiency)
- Scurvy (vitamin C deficiency)
- Brittle skeleton (electrolyte and micronutrient deficiencies eg vitamin D)
- Mobility (muscle weakness)

Less obvious effects

- Poor wound healing (creation of new cells)
- Poor immune function
- Decreased cardiac output (functional muscle compromise)
- Poorer ventilation and hypoxic responses (functional muscle compromise)
- Secondary anorexia (possibly due to micronutrient deficiencies)

so that it becomes a juice-based supplement. While these are technically 'incomplete' due to the lack of essential fatty acids, they are also potentially more palatable to some patients. However, they can be very sweet-tasting and may require dilution with water immediately prior to consumption in a similar manner to diluting a fruit squash. It is possible that prolonged consumption of juice-based supplements without an alternative source of essential fatty acids could lead to essential fatty acid deficiency, which may present as dry, fragile, flaking skin.

Pre-digested or elemental supplements are suggested to be of potential benefit for individuals with maldigestive states (eg pancreatic disease), but they can worsen symptoms in malabsorptive states due to the osmotic effect resulting from their high osmolality.

Sodium-supplemented sip feeds are not commercially available (and so are unlicensed), but may be of benefit to patients with a high output small bowel stoma who can readily become salt (and water) depleted. This treatment should always be undertaken under the care of a specialist; a sodium chloride injection may be added into the sip feed of these patients immediately before consumption to give a final sodium concentration of between 100 and 120mmol per litre.

ONS with a minimal composition are also available that provide only a single or limited number of nutrients. These products are unlikely meet a nutritional deficit without an alternative source of the missing nutrients because they are incomplete, and should be used only with specialist advice and regular review.

Most ONS are gluten-free and suitable for patients with coeliac disease, but it is worth checking in individual cases to limit avoidable steatorrhoea. Most prescribable ONS are also lactose-free, but again, it is worth checking in individual cases.

Sip supplement interactions

Patients prescribed ONS are also likely to have co-morbidities and/or be taking other medicines, whether prescribed or not. This means physical and pharmacological interactions need to be considered to ensure the safe and effective use of ONS.

Precipitation within the gastrointestinal tract of ONS with other concurrently administered medicines will limit the absorption of both the ONS and the interacting medicine, preventing the full intended benefits of each treatment. ONS can interact to form a precipitate with medicines that:

- are primarily an electrolyte source (eg calcium tablets or effervescent potassium)
- contain electrolytes (eg antacids)
- may precipitate with either milk or electrolytes (eg tetracyclines).

Interactions may be very significant, for example if electrolyte precipitation occurs with ONS this is likely to limit the intended supplementation effect. It is therefore important to advise the separation of ONS from physically-interacting medicines, especially as individuals may gradually sip an ONS rather than drink the whole supplement at once, effectively prolonging the duration of ONS administration. Ideally administration of ONS and an interacting medicine should be separated by two hours. This may be reduced to one hour if the interaction is less critical (with adequate monitoring), but a longer window may be required if the patient has gastroparesis and/or some other form of gastrointestinal dysmotility.

In some cases, the dose of an interacting medicine may need to be increased to limit the risk of poor absorption.

ONS may affect control of blood sugar levels, especially in diabetic patients, and particularly with juice-based supplements due to their greater carbohydrate component (which is mostly partially hydrolysed starch). The effect of ONS on good blood glucose control may require specialist adjustment of anti-diabetic medicines.

ONS may contain vitamin K, and while this is often included in only a very limited quantity, in principle it is a warfarin antagonist and could therefore affect an individual's INR, requiring careful monitoring and, if necessary, adjustment of warfarin dosing.

Individuals with pancreatic insufficiency who require pancreatic enzyme replacement to assist with digestion and subsequent absorption of their diet may also require enzyme replacement for standard ONS, typically 10,000 units per standard complete or juice-based sip feed. Pre-digested or elemental ONS are much less likely to require concurrent enzyme replacement in these patients to ensure adequate absorption and an appropriate stool consistency, because the action of the enzymes becomes less relevant.

Sip supplement prescriptions

ONS are usually recommended by a specialist who is often, but not always, a dietitian, or are prescribed by a GP. Despite this, pharmacists have a valuable role to play in their appropriate use (see table 3, above right).

Prescribers should confirm the prescription complies with these recommendations by using the endorsement 'ACBS' on the prescription. If this endorsement is missing, the pharmacist should not add it and will still receive payment following dispensing. However, the prescriber may have to justify the cost of the prescription to their PCT as it could be taken to be for an unapproved indication.

Unless specified, a variety of flavours can be supplied depending on the patient's preference, and a dispensing fee for each one can be claimed.

Some patients do not require, or do not take, all of their prescribed supplements, for example due to taste fatigue or a change in clinical condition. This may lead to 'stockpiling' of prescribed ONS, for which a clinical review is indicated.

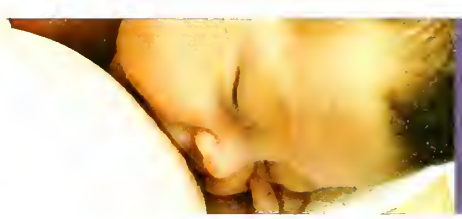
Further reading and a table of ONS indications is available in the full version of this article online at www.chemistanddruggist.co.uk/update

Peter Austin is a senior pharmacist at Southampton University Hospitals NHS Trust

Download a CPD log sheet that helps you complete your CPD entry when you successfully complete the 5-Minute Test for this Update article online (p18).

Table 3: Tips for pharmacists

- Patients with unintended weight loss associated with poor nutritional intake should be referred to the GP or a dietitian for a nutritional review.
- With repeat prescriptions for sip feeds, check with the patient how they find their supplements and whether they have any adverse reactions (eg loose stools). Poor compliance or malabsorption indicates the need for a referral to the GP or a dietitian as appropriate. This is in order to ensure both adequate and effective nutritional intake and to avoid stockpiling of unused supplements.
- Offering a range of flavours and/or textures of ONS may prevent taste fatigue.
- Milky-type sip feeds can usually be diluted with milk, and juice-based sip feeds can usually be diluted with water immediately prior to use in order to improve palatability. Recipes may also be available from the manufacturer.
- Sip feeds are usually more palatable chilled.
- Watch out for dry, fragile, flaking skin with prolonged use of 'juice-based' sip feeds, as this indicates referral to the GP.
- Consider physical and pharmacological interactions of sip supplements with both other medicines and co-morbidities.
- Contact the prescriber if the 'ACBS' endorsement is missing from prescriptions to clarify whether this is intentional. While prescription payment does not depend on this, it is a courtesy that will likely support the pharmacist-prescriber relationship.



NEXT WEEK
Update provides your essential guide to breastfeeding

Adult oral sip supplements

Reflect

What are the criteria for defining malnutrition and those at risk of malnutrition? What considerations should be taken into account when prescribing juice based supplements? Which medicines might interact with oral nutritional supplements (ONS)?

Plan

This article describes ONS and includes information about malnutrition, the use of sip supplements and the types available. It also discusses interactions with other medicines, prescribing and useful tips for pharmacists.

Act

- Find out more about the factors affecting malnutrition in the elderly from the dietetics.co.uk website at http://tinyurl.com/ONS10.
- Find out more about the Malnutrition Universal Screening Tool from the British Association for Parenteral and Enteral Nutrition at http://tinyurl.com/ONS222.
- Read about nutritional support in primary care on the Patient UK website at http://tinyurl.com/ONS111.
- Revise your knowledge of the range of ONS available by reading Appendix 7 Borderline substances in the BNF.
- Review any patients you have who regularly use ONS, thinking about how you could improve the services you provide. Identify those who might benefit from an MUR.

Evaluate

Are you now familiar with malnutrition and oral nutritional supplements? Do you know who they are suitable for and what interactions you should be aware of? Could you give advice about them to your patients?

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Practical Approach — Test yourself in this everyday pharmacy scenario

What's causing pain around the eyes?

At the Update Pharmacy a woman has asked to speak to the pharmacist and has been referred to David Spencer, who sees her in the consultation area. David asks how he can help.

"Basically, I want something for this nasty pain I've had around here for the last couple of days," the woman says, passing her fingers across her forehead between her eyebrows and beneath her eye sockets.

"Did it just start like that?" David asks.

"Well, that's not the whole story, I suppose," the woman replies. "I had a nasty cold about a week ago. I thought it had cleared up. I had a runny nose, but it stopped. Then it started to feel blocked up, the catarrh came back, but thick this time, and the pain started."

"Is the catarrh clear, or coloured at all?" David asks.

"It's a nasty, yucky yellow."

"Oh," David says, "in that case I think you need to see your doctor."

"That's why I've come here," the woman replies. "I phoned up for an appointment, but the receptionist said that it didn't sound urgent and they couldn't fit me in for three days."

"I think that you're still going to need to see your doctor," David replies, "but in the meantime I can recommend something to ease your symptoms."

Questions

1. What is the condition the woman is suffering from?
2. What are the characteristic symptoms?
3 What is the cause?
4. Why will the woman need to see her doctor?
5. What are the features that might distinguish the condition this woman is suffering from its more trivial form?
6. What can David recommend to ease the symptoms?
7. What signs or symptoms would cause David to make urgent referral to the doctor?

Answers

1. Acute rhinosinusitis, inflammation of one or more of the paranasal sinuses.
2. Nasal blockage or congestion; discharge or postnasal drip; facial pain or pressure; reduction or loss of smell.
3. Common cold viruses cause mucosal swelling and obstruct the sinus openings into the nose. Symptoms result from increased mucus production, reduced drainage, ciliary paralysis, and stasis of secretions.
4. Secondary bacterial infection has occurred and will need to be treated with a course of antibiotic.
5. Duration longer than seven days; purulent green or yellow nasal discharge; history of improvement, then deterioration in symptoms; fever and general malaise; facial pain and tenderness, particularly if unilateral or asymmetrical.
6. Steam inhalations to help liquefy mucus; analgesics; decongestants: oral (pseudophedrine, phenylephrine), topical (oxymetazoline, xylometazoline, phenylephrine, ephedrine).
7. Eye redness, swelling or other apparent eye abnormality; neck stiffness, drowsiness, photophobia, severe generalised headache, visual disturbance, unsteadiness.

Reference

Lindbaek M, Hjortdahl P. The clinical diagnosis of acute purulent sinusitis in general practice – a review. Br J Gen Pract 2002;52:491-5.

Got an idea for a Practical Approach scenario or would you like to write one? Email your suggestion to: **haveyoursay@chemistanddruggist.co.uk**

ETHICAL DILEMMA

This series aims to help you make the right decisions when confronted by an ethical dilemma. Every month we present a scenario likely to arise in a community pharmacy and ask a practising pharmacist and/or a member of the Pharmacy Law and Ethics Association (PLEA) to comment on the legal and ethical implications of the actions open to you. Readers are invited to have their say at **haveyoursay@chemistanddruggist.co.uk**

Can you take the 'easy' route to MURs?

The dilemma

As a busy pharmacist you have embraced the opportunity provided by the NHS contract to provide additional services [illegible] your skills and knowledge. MUR services have taken off [illegible]. Until now you have concentrated on reviewing those patients with complex medication regimens, but have heard that other pharmacists are reviewing patients with one main indication such as asthma or hypertension. These raise fewer issues and are therefore the easy options. You wonder if this route would be ethical.

The NHS contract in England and Wales allows pharmacy contractors to claim for a maximum of 400 MURs per year. At £28 per review this can represent considerable income. The aim of payment for these reviews is to enable patients to get the best from their medication by establishing dialogue with both the patient and their GP.

The NHS provides a service specification and while the proposal under consideration is not outside the framework, this 'cherry picking' approach is not quite what the NHS had in mind as a more clinical role for pharmacists.

Ethical considerations

Pharmacists are required to be honest and trustworthy (Principle 6 of the Code of Ethics) and comply with legal, and in this case contractual, requirements. Their judgement is also expected to not be impaired by commercial interests (Principle 2.2). Choosing only 'easy' reviews could be seen as being influenced by financial considerations.

According to the Code of Ethics, registration as a pharmacist requires you to use your skills to benefit service users, maintain good professional relationships and promote trust and confidence. In this situation, making the care of patients your first concern (Principle 1) would require pharmacists to prioritise time for those patients who would benefit most from an MUR. In particular, principles 1.5 and 1.6 concern requirements to ensure the effective use of clinically appropriate medicines.

The fact that there is a contractual agreement in place does not absolve a pharmacist from the need to ensure that the patient is treated appropriately.

Choosing 'easy' targets might not show the profession in a good light.

Ruth Rodgers MRPharmS PhD BPharm Hons is a senior/clinical lecturer in pharmacy practice, Medway School of Pharmacy, Universities of Kent and Greenwich

What the law says

The criteria for providing MURs as an advanced pharmaceutical service in England are contained within The Pharmaceutical Services (Advanced and Enhanced Services – England) Directions 2005, which can be found at Part VIC of the Drug Tariff.

The Directions state that patients are only eligible for MURs if they have been receiving pharmaceutical services from the pharmacy for a period of at least three consecutive months and have not had an MUR in the preceding 12 months (except in limited circumstances).

PCTs may notify pharmacists in their area of the categories of patients who may benefit from an MUR, but there is nothing to prevent pharmacists from offering MURs to patients in other categories.

While there has been some discussion in the pharmacy press about the targeting of MURs, the Directions have not been changed so far.

Noel Wardle is a solicitor at Charles Russell LLP, specialists in pharmacy law

More dilemmas are online at www.chemistanddruggist.co.uk/ethicaldilemma

PLEA

PLEA is an association of pharmacists interested in law and ethics, and lawyers or ethicists specialising in pharmacy, with the aim of promoting understanding of the ethical basis for professional judgement
www.wingfieldworks.co.uk/plea/index.html

CPD Reflect • Plan • Act • Evaluate

Health and wellbeing at work is important for both employees and pharmacy businesses – without healthy, happy staff, customer service is likely to suffer. This is the fifth in C+D's monthly series of guides and tips on improving your wellbeing, which is covering topics from establishing a work-life balance to preventing crime in your pharmacy. If there is a health and wellbeing issue you would like us to cover, email jennifer.richardson@ubm.com.

YOUR HEALTH AND WELLBEING AT WORK PART FIVE

Avoiding injury and illness

Emma Wilkinson looks at simple steps pharmacists and employers can take to cut the risk of repetitive strain injury (RSI) and other work-related illnesses

A sore back from being on your feet all day, eye strain from reading bureaucratic small print, tension headache from being overworked: any of these sound familiar? All are workplace-related injuries or illnesses that pharmacists are at risk of. For the purposes of data collection the Health and Safety Executive (HSE) classes community pharmacy as a retail business, and figures show that in this category reported injuries have fallen over the past decade and work-related ill health is lower than in other industries.

That said, in 2008-09, the Labour Force Survey showed that an estimated 3.1 million working days were lost in the retail sector due to workplace injury and work-related ill health.

Although there are no specific figures for pharmacy, the types of work-related illness and injury that pharmacists are at risk of are pretty clear. And most are things a pharmacist might well pick up in patients – but possibly overlook in themselves and their staff.

Musculoskeletal disorders, which include lower back pain, joint pain and RSI, are the most common workplace-related illnesses – yet there are simple ways to prevent them and to stop them getting worse in staff who already have these problems.

When it comes to back pain, whether work-related or a pre-existing condition, the HSE recommends: trying to take regular breaks; if sitting, making sure your chair is comfortable and supports your back; to get up and stretch; and to vary your tasks as much as possible so you are not doing the same movements for prolonged periods of time.

RSI or, to use the medically correct term, upper limb disorder, basically means any kind of tenderness, aches and pain, stiffness or numbness in the arms, shoulders or neck.

Often made worse by work, these injuries plague those who find themselves doing the same manoeuvre over and over, such as using a computer mouse or typing.

Uncomfortable working postures or working in an awkward position and poor working environment and organisation, such as bad lighting, work pressure or lack of breaks, can also contribute to these sorts of strains.

It is also important to point out that organisational factors such as high workloads, tight deadlines, and lack of control of the work can increase the risk of back or upper limb problems because stress can cause more tension in the muscles.

According to the NHS, one in 50 workers in the UK has reported some sort of RSI and a diagnosis cannot always be made. Carpal tunnel syndrome, tendonitis and writer's cramp are among the conditions that can occur or be made worse by work, often through use of computers.

The key with RSI is to get treatment as soon as possible because, although initially the symptoms may only happen while carrying out certain tasks at work and ease off once relaxing at home, it can become more permanent and even irreversible.

It is common for the problem to develop over a long period of time and pharmacists should be quick to act if they have any symptoms.

5 key warning signs

There may be problems in your pharmacy if you notice that staff:

1. Take more time off for illness
2. Report more injuries or pain and discomfort in the upper limbs
3. Modify their workstations or the tools they use
4. Appear reluctant to perform particular tasks
5. Wear bandages or splints

Employer responsibility

Your employer has a responsibility to perform risk assessments and put in place reasonable measures to reduce that risk as well as acting on any reports of ill health caused by work.

This includes a legal duty to try to prevent work-related RSI and ensure that anyone who already has the condition does not get any worse.

RPSGB president Steve Churton says: "Employers are responsible for the safety of their staff and we expect them to ensure that the working environment is as safe as possible so their staff can carry out their duties without injury.

"This includes providing the correct equipment needed for the job and the relevant training and support to use it correctly."

John Evans, superintendent pharmacist at Asda, adds that he is not aware of any specific issues on work-related illnesses raised by Asda pharmacists, but the company has taken several steps in recent years to make the working environment more comfortable. This has included improving the lighting and adjusting the height of the dispensing benches.

One issue that all pharmacists face, he says, is being on their feet for the long shifts. "Any pharmacist will tell you that being on your feet all day really hurts – you get leg ache and back ache but you do get used to it.

"We found during visits to a number of our stores that they had put mats underneath the computer area which were softer on the feet.

"Pharmacists found that their legs didn't ache as much so we now offer them to stores that want them."

When it comes to using computer equipment, RSI is not the only risk. Eye strain can also be a problem and pharmacists have the extra challenge of having to read small print on medicines. Good lighting is important in general but there are specific regulations covering use of 'display screen equipment'. Once more the onus is on employers to safeguard their staff and one of the requirements is that they provide eye tests on request as well as information and training.

Martin Crisp, superintendent pharmacist at Superdrug, says the multiple is just embarking on a project to make sure the working environment is as supportive for pharmacists as possible.

"We're looking at things like the mats, monitors, lighting – making things more ergonomically friendly.

"One of the things we did a couple of years back was to put all the monitors at eye height, which made a big difference.

"It's often the little things that can really help and we hope to be finalising the project next year."

He said one reason for reviewing this now was that more and more equipment was becoming available to prevent work-related injuries and illnesses.

For independent pharmacies there is a wealth of advice on the HSE website on protecting your staff, including how to make sure you are complying with the law and also how to carry out risk assessments.

One key publication for independent pharmacies, which perhaps do not have access to the occupational health facilities of larger companies, is a booklet designed to help employers and managers in small businesses to understand upper limb disorders. This can be downloaded at www.hse.gov.uk/pubns/indg171.pdf.

An NPA spokesperson points out that prolonged periods of work at a computer without a break may increase the likelihood of visual, physical, mental fatigue and work-related upper limb disorders and stresses the importance of regular breaks.

He says that, for any health and safety issue, pharmacists can call the NPA Employment Advisory Service Helpline – 24 hours a day, Monday to Sunday. The NPA is also planning to publish some advice in the coming weeks on reducing workplace stress – another factor in workplace-related illness leading to tension headaches among other symptoms.

"Preventing stress occurring is far easier than dealing with the consequences and it is important that the whole organisation is involved in the processes of identifying issues and dealing with them immediately," the NPA advises.

10 steps to a safer working environment

Assess your working environment and speak to your employer if you feel there is anything that could be improved. Your assessment should answer the following questions:

1. Are any surfaces you work at set at a sensible height?
2. Is the lighting adequate?
3. Do you have regular breaks?
4. Are you able to vary some of the repetitive tasks you do?
5. If sat at a workstation, do you have good posture? The height of your chair should allow you to place your forearms horizontal to the desk and your eyes at the same height as the top of your computer screen.
6. Are there any trip hazards in your workspace?
7. Do you have to do any heavy lifting?
8. Do you have to bend or reach awkwardly to reach anything?
9. Would floor mats under the counter help to ease pressure on your feet?
10. Do you have any special requirements (for example are you pregnant, or do you have a pre-existing back condition)?

CPD Reflect • Plan • Act • Evaluate

Tips for your CPD entry on workplace injury and illness

REFLECT	Am I aware of my and my staff's risk of workplace injury and illness?
PLAN	Assess my and my staff's working environments.
ACT	Implement necessary changes to reduce the risk of injury and illness.
EVALUATE	Is the working environment safer and more comfortable?

C+D Senate

The new community pharmacy think-tank

TOPIC: **Defending against dispensing errors**

After C+D readers unanimously voted for the Elizabeth Lee case to be discussed by the C+D Senate, the Senators assess how much protection the CPS guidance on dispensing error cases will bring and what the profession needs to do next. **Zoe Smeaton** reports

We must do everything in our power to stamp out errors instead of writing moaning letters, the C+D Senate hears

The Senators

Angela Chalmers Pharmacist, Boots
Debby Crockford Area manager, Rowlands Pharmacy
Hilary D'Cruz Partner, Ansons Solicitors
Andrew Derham Commercial and supply chain manager, AstraZeneca
Ian Facer Chairman, NPA
Max Gosney News editor, C+D
Keith Howell Pharmacy manager, Delmergate Pharmacy, Kent
Peter Kelly National sales manager, Actavis
Mark Koziol Chairman, Pharmacists' Defence Association
Nick Lowen Director of commercial operations, GlaxoSmithKline
Gary Paragpuri Editor, C+D
Steve Poulton Director of commercial operations, Pfizer
David Reissner Partner and head of healthcare, Charles Russell
Zoe Smeaton Senior reporter, C+D

Does the CPS guidance make any difference?

David Reissner: "I think it's designed to make prosecutors think twice before prosecuting for a single dispensing error but it's obviously hugely disappointing because it doesn't do that. All the CPS [Crown Prosecution Service] has done is restate the code for deciding whether to prosecute or not. But that code was in place at the time Elizabeth Lee was charged. If prosecutors now were brought under pressure by families or by police there is no reason to suppose the situation would be particularly different."

Keith Howell: "As a pharmacist I don't feel any more protected. Looking at the CPS's original advice you would think that it would protect us anyway – it's difficult to see how prosecuting Elizabeth Lee was in the public interest given that she had a previously unblemished record and had made a genuine mistake. I suppose there is some protection but I just don't feel it – it feels like we are exposed."

Angela Chalmers: "I don't feel reassured by the guidance, either, and I don't feel protected. I just do all I can on a day-to-day basis to prevent something leaving my pharmacy in error."

Ian Facer: "As someone who is practising, I do feel a little happier that we perhaps have a little more protection than before, but clearly it doesn't go far enough."

Mark Koziol: "I actually think that although they still don't answer the main question, it gives a lot more for defence teams to get their teeth around. For example, it says that if the healthcare regulator has indicated it will take action or even might do so in the future then that could be used as an argument against prosecution being in the public interest. Defence lawyers should be able to use tools like that far more effectively now."

Hilary D'Cruz: "I agree the guidance opens some doors. There is now the opportunity to look at the public interest part. It also opens the door to bring in the pharmacy professional bodies to get their guidance and find out whether disciplinary action is going to be taken."

Mark Koziol: "And there is a section in there that says the Medicines Act will be reviewed and will be looked at with a view to decriminalising dispensing errors – that's a powerful message that sets the mood music. Unfortunately, that could be very different to the feeling when someone has died, a pharmacist is sitting in the cells and the police are absolutely determined to get their guy."

David Reissner: "The prosecution is entitled to look at the impact on the victim and the family of victim and take that into consideration, though. If the objective of the CPS guidance was to discourage prosecutions they could have come out more clearly and said so. The easy thing would have been to ask prosecutors to seek advice from the regulator, who has the expertise to determine what is a serious error and what isn't."

So what is the solution?

Ian Facer: "I've got concerns about what the right solution should actually look like. We've got to be careful what it is we're actually asking for and at the moment I just wonder whether, given the

experience we have got around the current Medicines Act, it might be better to try to firm up the guidance rather than messing with the Act [and decriminalising errors]."
Hilary D'Cruz: "But the Medicines Act is under review and it would be safer for pharmacy to make sure that single dispensing errors are excluded from the law. Guidance is just that – guidance. In my view you've got to change the law. In the meantime your professional bodies need to lobby fiercely to ensure this guidance is used appropriately."

David Reissner: "I think squeezing in parliamentary time for legislation changes is going to be quite difficult. We have a new government with quite a heavy legislation timetable so logistically it will be quite difficult to do. Instead I would make representations to the attorney general who is responsible for the CPS. I would say that this statement doesn't do the job and then say I wanted the CPS to say it wouldn't bring a prosecution without consulting the regulator."

Do we need to look to the pharmacy profession to do more to prevent errors?

Debby Crockford: "We need a culture in which we're not afraid to report errors. If humans are involved there are always going to be errors and the only way to improve practice is to self-report those. But pharmacists would be more comfortable doing that if errors were decriminalised."
Angela Chalmers: "We also need to look at pharmacists' attitude to errors. Some are quite happy to sit and write moaning letters about it, but what are they doing about it as professionals? Are they taking responsibility for the fact that they can make errors and doing everything they can to minimise them?"
David Reissner: "But you can't blame some pharmacists for not reporting. I dealt with a case recently in which an inspector had gone to a pharmacy after a report of a single error and asked to see the error log. They saw that the same locum over period of about two years had made 18 errors and then the locum and the superintendent ended up in front of the disciplinary committee on allegations of misconduct. That sort of thing needs to change."
Ian Facer: "I think there's a valid point on culture and how important patient safety is in what we do. It's going to be interesting because we're in an environment where we're going to be asked to do more for less, but there must come a point at which we can't do that and maintain patient safety."

And can manufacturers do anything more with packaging to help reduce errors?

Andrew Derham: "Packaging can help. With hospital tendering, for example, part of the process is us demonstrating how packaging is differentiated across a brand, to help avoid errors."
Steve Poulton: "We have used the NPSA guidance in changing our packaging, so now it's not an exercise in corporate branding but in easy recognition and differentiation between streingths and commonly co-prescribed products."
Nick Lowen: "It has to go beyond that too – there should always be research on that sort of thing even before drug names are agreed. It has to be an end-to-end process."

The Senate Ruling

1. **The CPS guidance is a step in the right direction, but doesn't go far enough.**
2. **Prosecutors should consult the professional regulator before bringing any cases against pharmacists making errors.**
3. **Changing the law might be a lengthy and difficult process.**
4. **Pharmacists need to think about how they can help reduce errors.**
5. **Extra regulation of packaging could help reduce errors.**

THE C+D SENATE
IN ASSOCIATION WITH actavis

Senators' top tips for reducing your error rates

"We need to do more auditing. Reporting errors should be a positive thing used as a self-audit tool. As well as recording errors we should also be recording every time we avert an issue because we spot an error on a prescription, for example."
Debby Crockford

"The simple solution is to follow your SOP. If you get down to that and follow every single step properly, every time, errors won't happen. I did a patient safety review on every near miss we had made in January and I realised my dispenser had got complacent. So I printed out a copy of the SOP and asked her to think about all the steps she was forgetting. Since then she has gone from making seven errors a week to being unlucky if she makes one."
Angela Chalmers

"[Lack of] rest breaks are the silent killer. In lots of the error cases we deal with exhaustion is a very serious factor. We need to look at this as a profession."
Mark Koziol

CPD Reflect • Plan • Act • Evaluate

Tips for your CPD entry on reducing dispensing errors

REFLECT	How much do you focus on patient safety?
PLAN	How can you review safety and start learning from errors?
ACT	Implement a patient safety review and error-recording protocol, involving your staff.
EVALUATE	Has patient safety improved?

Next week in C+D: The Senate delivers its verdict on how big pharma and pharmacists can work together more effectively

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CAREERS

Retirement changes and you

The government has proposed abolishing the default retirement age of 65. Lawyer Gareth Edwards explains what the impact will be on pharmacists – and their pensions

Currently, when employees reach 65, employers can compulsorily retire them without making any payment, providing the statutory retirement procedure has been followed. But this is all set to change, as the government has proposed the abolition of the default retirement age from October 2011 (www.bis.gov.uk/retirement-age).

Who will be affected?

All employees, apart from those due to retire – at 65 or later – before October 2011. In fact, the change in the law will affect some employees before 2011 because the government is also abolishing the statutory retirement procedures. These require the employer to give the retiring employee at least six months notice of retirement, which means notice under the existing regime must be given by April 1, 2011. To accommodate the change the government says it will introduce transitional arrangements by April 2011.

Will my employer be able to force me to retire before I want to?

It depends when you want to retire. Currently if you want to work beyond 65 you only have the right to ask your employer if you can do so. The employer does not have to agree to your request and does not have to give any reason for the decision, either.

Under the proposed legislation, employees who want to work beyond 65 should be able to do so more easily. However, it will depend on the steps the employer takes. Some employers, notably B&Q, Nationwide, BT and M&S already have no compulsory retirement age. Many employers may follow their example. This probably means that employees will be left to come to their own decisions about when to retire, although it will be necessary for employers to manage employees' capabilities and performance. An open retirement age may prompt more dismissals on performance or capability grounds.

Other employers may decide to set their own compulsory retirement age, which the new legislation will allow them to do. Managing retirement will become difficult for employers as they will need to be able to justify objectively the retirement age they set.

Proposed new rules will enable employers to set compulsory retirement ages

As yet there is little in the way of guidelines, but factors employers will need to consider may well include: health and safety considerations; the need to produce a happy workplace; and the need to give younger employees the opportunity for promotion. The onus will be on the employer to justify their decision. A retirement will be a dismissal and the employee can challenge the dismissal at an employment tribunal.

The changes are likely to create uncertainty for employers and employees alike until test cases can clarify the reasons an employer can use to justify the setting of a retirement age.

Will my employer be able to prevent me from retiring when I want to?

No. In order to retire it will still be possible for you to resign, giving notice under the terms of your contract of employment, and it will be extremely rare for an employer to refuse to accept your resignation.

How will the changes affect my pension entitlements?

One advantage of the default retirement age is that the employee qualifies for their state pension on retirement. This will change. Already the government is discussing plans to extend the age at which people can claim their state pension.

Private pension providers may see a change in the legislation as an opportunity to delay the age a pension can be claimed, in order to allow them to build up funds and to take account of the likelihood that people will be living longer.

However, if employers set a compulsory retirement age they ought to ensure that any pension scheme they provide will be flexible enough to permit this

Gareth Edwards is a partner in the employment team at Veale Wasbrough Vizards

CPD Reflect • Plan • Act • Evaluate

Tips for your CPD entry on retirement law changes

REFLECT	How will the abolition of the default retirement age affect me or my employees?
PLAN	Familiarise yourself with the new regulations.
ACT	Make sure you or your employees understand how these regulations will be applied in your pharmacy.
EVALUATE	Do I understand how the abolition of the default retirement age will affect me or my employees?

How employers should handle changes to retirement age

The abolition of the default retirement age presents employers with two options. First, employers can decide not to have a compulsory retirement age, but they will have to have clear policies and procedures dealing with capability and performance in order to manage employees whose performance may decline as they get older.

Second, employers can set their own compulsory retirement age, but will have to be able to justify it objectively.

Either option presents employers with new problems and uncertainties. Capability and performance management may be difficult or unpleasant when dealing with an employee who has given years of loyal service.

Setting a compulsory retirement age is also fraught with problems. The employer may retire the employee but it will be a dismissal and so the employee can make a claim to an employment tribunal. Claims will include unfair dismissal, redundancy and age discrimination. Employers will need to satisfy the tribunal that it is a retirement, that they have followed a fair procedure and be able to justify objectively the retirement age they have set. If the employer fails in these tasks they face paying tribunal awards for unfair dismissal, which is capped at £65,300, or compensation for discrimination, which is uncapped.

Ahead of the proposed changes, employers with employees coming up to 65 should ensure the correct notices – at least six months – are given under existing statutory retirement procedures.

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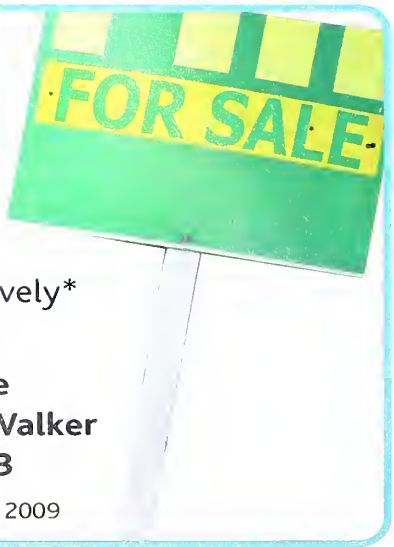

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Postscript...

Phoenix ready to ride again

Next week 56 cyclists will cycle 300 miles from London to Paris. But they're not just doing it for fun – it's a bid to raise £500,000 for Great Ormond Street Children's Hospital.

The Phoenix London to Paris bike ride is now in its 10th and final year, having raised a whopping £377,000 for the hospital since its inception.

Cyclists include Phoenix group company secretary Mike Blakeman and customer Marshall Glynn, two of only three to have ridden all 10.

They will be cycling alongside Phoenix CEO Paul Smith, who set the bike ride up 10 years ago, and C+D's projects director Patrick Grice is also donning Lycra for the good cause.

Mike Johnson, Rowlands' marketing manager, who completed the challenge last year, described the end of the ride as a great experience.

He said: "The sense of achievement was incredible. There were celebratory hugs, kisses and firm handshakes under the Eiffel Tower but it was straight to the hotel to start the celebrations properly with a glass of well-earned champagne."

You can sponsor the cyclists who are riding for Great Ormond Street Children's Hospital at www.justgiving.com/mike-johnson0

A view from the saddle

Numark managing director Tony Mottram is going to do the Phoenix London to Paris bike ride for the first time this month

How much have you raised so far? I have raised £2,300, which has beaten my target of £2,000.

Are you looking forward to the cycle? I am looking forward to the challenge and know it will take a great deal of physical ability but also a lot of psychological strength, too.

What kind of training have you done? I have been out on my bike most mornings before work doing about 15 to 20 miles, and when able also at weekends doing longer rides of 30 to 40 miles.

Will you do it again? I would probably be in a better position to answer that once I'm sat with a cold beer in Paris, but I would like to think I would.

Why are you raising money for Great Ormond Street Hospital? It's a charity that Phoenix has supported for the past 10 years. On a personal level my wife and I became parents in October last year and we are very fortunate to have a happy, healthy baby girl. I know there are some parents who are less fortunate as their children have no choice but to fight illness. Great Ormond Street Hospital is an organisation that helps children battle illness and provides support for parents at a time of huge challenge.

Calling all pharmacists and technicians. We want you to be our reader of the week. Email us at postscript@chemistanddruggist.co.uk

@The Web Hunter

I got slammed for my last column – and probably justifiably – for asking what the fuss was about Sainsbury's vending machines.

One commenter asked me how I would feel if someone found a clever machine to do my job. Ironically, in the US they have come up with a computer programme that can write sports reports, so maybe my end is nearer than I think.

This week Lloydspharmacy has been looking into all-in-one 'health villages', which have been praised by another commenter as good and clever thinking. And Boots' online private prescription service also won plaudits.

Both of the above examples, to me at least, seem like innovative thinking in an increasingly competitive market. And neither of them could be replicated by independent pharmacies, or indeed by smaller multiples or chains.

Now I don't want to keep poking a wasp nest by bringing these things up, but Superdrug's move to cut prescription charges and Sainsbury's vending machines are also innovative ways of gaining an advantage in the same competitive market.

Don't get me wrong, I am not saying: "Well, that's market forces, you had better get used to them." But what I would like to know is why your average Joe Pharmacist doesn't complain when Boots or Lloyds does something clever, but complains bitterly when it is done by a supermarket chain or a health and beauty retailer? Surely they all hit small pharmacists and have implications for pharmacy services.

The problem is that there are some pharmacists who consider themselves medical professionals first and retailers second: a group that isn't that good, necessarily, at retail. Then there are those who consider themselves medicinal retailers, who are good at marketing their services while maintaining a professional approach.

And last there are health and beauty retailers, who also happen to provide pharmacy services. And this is the group that many of you seem to have a problem with.

Am I getting close? Why is this? And which category do you fall into? Let me know – email niall.hunt@ubm.com, or leave a comment at www.chemistanddruggist.co.uk.

Niall Hunt is C+D's digital content editor

Last week's top stories on C+D's website

1. RPSGB boards slam proposed GPhC fees
2. Boots launches online prescription service
3. Lloydspharmacy investigates all-in-one 'health villages'

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